SUSTAINING AND REPLICATING SUCCESSFUL CHILD SURVIVAL ACTIVITIES IN PERI-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS

MIDTERM EVALUATION OF PROJECT HOPE/HONDURAS

Submitted to:

AID/FHA/PVC/CSH
Agency for International Development
Washington, D.C. 20523

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Submitted on:

October 7, 1993

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ACRONYMS

ARI	Acute Respiratory Infection
ASHONPLAFA	Family Planning Association of Honduras
CDD	Control of Diarrheal Disease
CESAMO	Health Center with physician
CESAR	Health Post
CHV	Community Health Volunteer
c s	Child Survival
EPI	Expanded Program on Immunization
FINCA	Foundation for International Community Assistance
HIS	Health Information System
KPC	Knowledge, Practice and Coverage
MOH	Ministry of Health
NGO	Non-Governmental Organization
PVO	Private Voluntary Organization
TT	Tetanus Toxoid

1. EXECUTIVE SUMMARY

The evaluation team, consisting of Laurel Cobb, an independent consultant, and Julianne Guy, the Assistant Director of Project HOPE's Maternal and Child Health Programs, spent ten days, August l-11, 1993, in Tegucigalpa evaluating the Project HOPE CS-VII project. The team was assisted by a Honduran evaluation committee headed by Carol Elwin, Director of Project HOPE in Honduras and Alicia Leiva, Coordinator of this project. The committee included the Ministry of Health (MOH) Area Chief, MOH staff, and a community health volunteer. The team and members of the committee visited each of the five MOH health centers with which the project is collaborating, interviewed MOH officials and staff CHVs, beneficiary families, and Project HOPE staff. The team observed project activities: feeding centers, demonstration gardens, training of CHVs, community health promotion and a monthly CHV meeting.

Project HOPE has made several important contributions in Tegucigalpa: First, it has contributed directly and indirectly to the development of skilled CHVs. Its contribution has been direct through training CHVs for 44 communities; it has also contributed indirectly to the formation of CHVs affiliated with other international PVOs which are reproducing Project HOPE's excellent CHV child survival training program in their own training programs. Secondly, Project HOPE has contributed to the development of the MOH multi-disciplinary teams which are responsible for all CI-IVs in their catchment area: Project HOPE has contributed both to their ability to recruit and train CHVs as well as to their increased service orientation in the community.

Project HOPE is to be commended for the effort it has made, and the success it has had, in implementing multi-institutional collaboration, so important for urban child survival program success. Project HOPE is singled out by MOH leadership as being unique in Tegucigalpa in the extent to which it seeks to collaborate with the MOH. Project activities are often the successful collaboration of Project HOPE, the MOH, community groups and other local and international institutions. Such development is slower but creates a sounder foundation for sustainable community child survival programs

The project, although behind schedule, is on the right track. The staff is competent and is collaborating with a committed MOH leadership. The following actions are recommended to improve project performance and increase the potential for impact. Project HOPE should:

1. Assist the MOH to develop and implement a program of in-service training in the key CS interventions of ARI, CDD, EPI, nutrition and maternal health for the CESAMO field teams. The focus for the next year should be on training staff in the five CESAMOs in which Project HOPE is currently collaborating with the MOH and bringing that staff to an agreed upon level of competence.

2. Sponsor a workshop on" CHV Incentives" for MOH field teams and other PVOs working in the metropolitan region.

3. Work with the MOH and other international PVOs working in CS in Tegucigalpa (particularly those funded by AID) to develop a single CHV reporting format which meets the data needs of the CHV, the MOH, AID and the respective PVOs.

4. Develop a project HIS which provides timely, accurate and sufficient data for monitoring the progress of child survival interventions on a regular basis.

5. Work with the MOH to define an "active" CHV and be more willing to move into the passive status CHVs who are not meeting those expectations.

6. Relative to project extension, priority should be given to expanding collaboration with the MOH in additional communities covered by the five CESAMOS with which Project HOPE is currently collaborating, if there are needy communities without international assistance in the catchment area of those five CESAMOs.

2. BACKGROUND

This project is located in Tegucigalpa, the capital of Honduras. The Ministry of Health (MOH) divides the country into nine health regions, including the Metropolitan Health Region (MHR) which encompasses Tegucigalpa. The MHR is further subdivided into two health areas. The project is working with five MOH health centers (CESAMOs), one MOH health post (CESAR), and forty-four communities in their catchment area in Area 1 which covers the predominantly marginal communities in the north and southeast of the capital.

3. ACCOMPLISHMENTS

This project, expanding a CS-IV project, began in September 1991' and has been operating twenty-three months. It is an urban child survival project and Project HOPE staff face a group of problems classic to poor urban communities in developing countries:

- traditional child survival issues of CDD, EPI, ARI, nutrition, water and sanitation combined with First World issues of drug abuse, single parenthood and family violence;
- * high mobility into and out of informally and often recently settled communities;
- * weak or no community organizations;
- * intra-sectoral problems needing intra-sectoral solutions;
- * many institutions addressing specific and often overlapping aspects of the various problems.

Project HOPE is admirably attempting to address the major causes of child mortality and morbidity under these challenging conditions, in collaboration with five Ministry of Health CESAMOs (health centers) serving 44 communities.[2] CS activities were begun with one CESAMO, Las Crucitas, and 20 communities in its catchment area during CS-IV (phase 1); sustainability was to be achieved during CS-VII. Additionally, in the current project, Project HOPE extended activities to four further communities in Las Crucitas and to four more CESAMOS, San Francisco, Alemania, Villa Adela and 3 de Mayo and twenty four communities in their catchment areas (phase 2).

The strategy of working with CESAMOs, communities and community health volunteers (CHVs) in the two phases is different. In phase 1, the MOH, in collaboration with Las Crucitas, assigned Project HOPE communities within the Las Crucitas catchment area with which to work; Project HOPE then recruited, trained, and supervised CHVs in those communities. It continues to work directly with those CHVs serving Las Crucitas communities. The strategy begun in CS-VII is different and more sustainable. Project HOPE

'Due to the availability of CSIV funds, CSVII monies were not used until March 1992.

'Administratively, the Ministry of Health has divided the country into nine health regions. Each of the nine regions has a regional administrative office and regional Director. Each region, in turn, is divided into health areas. The areas are further divided into sectors; each sector runs a network of local health centers. A CESAMO (Centro de Salud con Medico) is a health center with one or more physicians and licensed professional nurses, offering a full range of curative and preventive services. A CESAR (Centro de Salud Rural) is a small health center, staffed with one or more auxiliary nurses who can provide primary care and a limited range of curative services. At the community level, in theory, the MOH supports volunteer health workers and midwives.

developed agreements with the San Francisco, Alemania, Villa Adela and 3 de Mayo CESAMOs whereby Project HOPE staff trained CESAMO staff in the recruitment and training of CHVs; CESAMO staff selected the communities and recruited the CHVs. Project HOPE then assisted the MOH to train those CHVs. Throughout this report a distinction will be made between the two phases.

CS-VII project objectives fall into two areas: process and coverage. In as much as this is a mid-term evaluation, more data is available on process accomplishments than on coverage.

PROCESS OBJECTIVES

Objective I: Achieve sustainability of the CS-IV project in Las Cmcitas by end of year 2. The anticipated outputs were:

a. Four auxiliaries capable of training, supervising and maintaining 160 CHVs and maintaining CS-IV coverage levels;
b. auxiliaries and CESAR/CESAMO staff participate in continuing education;
c. defaulting CHVs replaced by new volunteers and trained by Las Crucitas staff;
d. at least 80% of CHVs continuing promotional activities;
e. Las Crucitas CESAMO resource allocation and planning reflects needs of community outreach system.

Four competent Project HOPE auxiliary nurses are working in Las Crucitas to support and supervise 160 "active" CHVs, in twenty communities, through community visits, monthly group meetings and review of reports. The level of effort, though, of those CHVs is unclear. Each CHV is responsible for an average of 40 families in their community. Interviewed CHVs stated they usually visited or met with 2-3 families a week or a total of about ten a month.[3] However, the number of CHV reports on family visits or contacts for health promotion and education received by the central office does not support this level of effort.' Only about 100 family visit reports are received at the central office each month, indicating that, on average, only 63% of the CHVs visited even one family a month. The evaluators suspect the problems are twofold: first, many family visits are not reported and secondly, many so-called "active" CHVs are providing health education, promotion and referral on such an infrequent basis that they should be reclassified as "inactive",

The CESAMO has included the 20 communities in its annual plan; however, at this point, there remains a great deal to be accomplished to make the activities to date sustainable. First, Project HOPE must verify the Project HOPE CHV level of effort in Las Crucitas (i.e., the number of families the average CHV is visiting on a regular basis), and thereby verify their

[3]The team interviewed six CHVs about their level of effort and reports during the regular monthly CHV meeting. All CHVs were active enough to be attending such meetings. They were not, however, a representative sample of the 160 CHVs termed "active" by the project.

[4]CHVs are responsible for completing several reports: a family health record (ficha familiar de salud), a housing survey, a report on immigration/emigration of family members and on family visits. The first two reports are completed at the beginning of contact with a family, the third whenever people move into or out of one of the assigned families. The fourth report, the report on family visits, is to be completed whenever a CHV visits a family in their home and provides health education and promotion.

level of effort it is transferring to Las Crucitas. Together with the MOH, it should set clear expectations for CHV level of effort and should be willing to reclassify as "inactive" those CHVs who are unable to serve at that level.

Secondly, Project HOPE must redouble its efforts at successful collaboration with Las Crucitas where there have been problems in the last year for a variety a reasons.' It is important to note that the MOH Area Chief who supervises both Las Crucitas and Project Hope's collaboration with the MOH in Tegucigalpa states that responsibility for the problems lies with Las Crucitas. In any event, Las Crucitas is unable to absorb any Project HOPE auxiliary nurses at the projects' end, due to impossible MOH budgetary constraints. CESAMO staff also express reluctance to assume responsibility for the 160 CHVs whom they identify as Project HOPE's rather than the CESAMO's and express an inability to supervise and support them at the level of quality which Project HOPE has. During the evaluation, these collaboration problems were addressed. One meeting was particularly useful. It was attended by the Project HOPE CS staff, the evaluators, the MOH Area Chief, the Las Crucitas Director and the multi-disciplinary team which is to supervise and support the CHVs. Las Crucitas' reasons for not assuming responsibility for the CHVs were dismissed by the MOH Area Chief as being groundless; the CESAMO staff were instructed to collaborate in the transfer of responsibility from Project HOPE to the CESAMO. Such explicit instructions from high-level MOH personnel w-ill promote, at least, overt compliance. Successful collaboration will take continued diplomacy on Project HOPE's part.

Objective 2. Replicate the CS-IV project in other marginal areas of Tegucigalpa, with strong MOH leadership. The anticipated outputs are:

a. Four CESAMOs assign 8 auxiliaries, 5 social workers and 3 health educators to community-based activities.
b. Twenty-two CESAMO staff (4 nurses, 8 auxiliaries, 4 health educators and 6 social workers) trained in CS.
c. Eight auxiliaries and 5 social workers trained in training and supervision of CHVs.
d. Two hundred and eighty CHVs trained and active in PA2 in year 3.

Project HOPE did not replicate the CS-IV project in other marginal areas of Tegucigalpa, but rather learned from the problems in Las Crucitas and employed a different strategy from the onset with the four additional CESAMOs. The result is successful and harmonious collaboration. These CESAMOs have been responsible for CHV recruitment, training and supervision for which Project HOPE has provided technical assistance and training. Additionally, Project HOPE has provided greatly appreciated supplies, materials and logistical support. The identified problems which exist in Las Crucitas have not occurred to the same extent in the other four CESAMOs.

[5] Those reasons include: the phase 1 methodology of Project HOPE; that fact that the CESAMO is the center for MOH union activities in the city; personalities and resistance on some staffs part to adapt to the new MOH multi-disciplinary team approach to supporting CHVs. Under the previous approach, CHVs reported to the Department of Social Work in each CESAMO.

In all 5 CESAMOs, CESAMO staff now work in multi-disciplinary teams, including auxiliary nurses, social workers, health promoters and vector control personnel.[6] These teams (a total of 55 people) have received Project HOPE training on the recruitment, training and supervision of CHVs. Additionally, as a result of the results of the recent test of knowledge of CS technical interventions, Project HOPE will support the MOH in the provision of technical CS training for these teams. (See Section 7.6)

Two hundred and thirty-one CHVs have received both of the two-part 80 hour CHV training program An additional 139 CHVs have received the first half (40 hours) and 76 recruited CHVs will complete both parts in the next year. If the training is completed as planned, 446 CHVs will be fully trained at the end of the project.

Because the training of the 231 CHVs was recent and because training is still in process, there is no data yet on the activities of these CHVs in their 24 communities. All outcome data presented below is for the original 20 communities. As will be noted, the Project HOPE health information system (HIS) is not collecting and presenting timely, accurate and sufficient data for monitoring project activities. The data from that HIS certainly underreports Project HOPE's level of effort.

Objective 3. Conduct a baseline survey in year 1 and one KPC survey in year 2 and 3 to monitor project achievements. The plans were:

a. Baseline survey in the new communities completed by May 1992
b. KPC surveys in the old and new project areas in August 1993 and January 1995

An excellent baseline study was completed in February 1992. A midterm KPC survey was not conducted in PA1 due to time constraints from the staffs intensive involvement in a national vaccination campaign (May-July); nor in PA2 because activities with families at the community level had not been ongoing for a period long enough to monitor changes. The project will conduct a KPC in the original 20 Las Crucitas communities in October 1993 and a second KPC in the new 24 communities in June 1994.

Objective 4. The project will increase community participation in CS interventions. The anticipated outputs were:

a. by year 3, 40% of the participating communities will have functioning lactarios to provide supplemental feeding to malnourished children under 2;
b. by year 3, each catchment area will have a functioning CHV directive;
c. organize at least one new community organization per community.

Project HOPE has helped establish community feeding centers (lactarios) for malnourished children under five years and for malnourished pregnant and lactating women in four of the forty-four communities. All four centers are in the original 20 communities in which Project HOPE has been working since CS-IV. The centers are an example of the benefits and problems with multi-institutional collaboration. Project HOPE has helped to establish women's

[6] At the cited meeting during this evaluation, the Las Crucitas staff indicated that, contrary to MOH policy, there were no auxiliary or professional nurses on the multi-disciplinary team. The MOH Area Chief, thereupon, ordered the CESAMO to comply with MOH policy and add nurses to the team.

clubs (clubs de amas de casa) which, in turn, may establish a feeding center, if licensing can be obtained from the Junta National de Bienestar Social (National Social Welfare Committee). CARE supplies the food stuffs (rice, beans, flour, milk and oil) on a carefully spelled-out ration basis. The women's clubs work locally to raise additional funds and foodstuffs to supplement the CARE rations.

The process of such multi-institutional collaboration is slow. However, the four feeding centers appeared very successful. Each provides one nutritious meal a day, five days a week to 60-80 malnourished children and mothers. The weight of the children is monitored monthly. A sample of the weight of 50 children indicated that 86% gained wight during the two months previous to this evaluation; the remaining 14% maintained their weight. Moreover, two centers own the building in which they are operating. Each of the four receives the support of a number of community groups, including the CHVs in the area.

In each of the forty four target communities, Project HOPE has either strengthened an existing community group or, where none existed, helped the community to organize one.

COVERAGE OBJECTIVES

Objective 1. Immunization coverage of children It-23 months will reach 90% and immunization of women offertile age with TT5 35%. The anticipated increases are:

a. Children 12-23 months - % covered:
- year 1 (baseline) 85%
- year 2 90%
- year 3 90+%

b. Women of fertile age - % covered:
- year 1 - 20%
- year 2 - 30%
- year 3 - 35%

Project HOPE staff are actively collaborating with the MOH in expanding immunization coverage through education, promotion and logistical support for bi-monthly community mini-campaigns. In the original 20 communities of the project, Project HOPE has participated in fifteen campaigns and mini-campaigns. No data are yet available on coverage; they will be obtained in the 1993/4 KPCs.

Objective 2. By year 3, Litrosol will be used in 50% of all diarrhea1 episodes of children under 2 years. The anticipated outputs are:

a. use of Litrosol increases each year, as measured by KPC surveys, to at least 50% in year 3.
- Year 1 (baseline) 35%
- Year 2 45%
- Year 3 50%

b. by year 3, 50% of mothers will be knowledgeable about the nutritional management of diarrheal episodes.
- Year 1 (baseline) 30%
- Year 2 40%
- Year 3 50%

Diarrhea is the second leading cause of child mortality in Tegucigalpa. The baseline study indicated that during the two weeks previous to the study, the incidence of diarrhea had been 37% in the target communities. Project HOPE has trained CHVs who are promoting ORT, educating women in the nutritional management of diarrheal episodes and referring children to the CESAMO as appropriate. Unfortunately, the Project HOPE HIS, although designed to present monthly statistics on CHV detection of diarrhea, is not presenting accurate data on the level of their efforts. The report of activities undertaken in each community indicates that in the preceding year, the 160 "active" CHVs detected only 83 cases of diarrhea in the 20 communities with a total of 3,403 children under five years. Such data are presumably only a partial accounting of Project HOPE's activities and as such do not permit timely and productive monitoring of these activities. Project HOPE must develop a HIS which provides timely, accurate and sufficient data for monitoring project activities.

Objective 3. By year 3, at least 70% of ail mothers will be knowledgeable about breastfeeding and weaning and the nutritional needs of healthy, iii and recovering child and growth faltering. It was anticipated that the following increases would occur:

Year 1 (baseline)	*60%*
Year 2	*65%*
Year 3	*70%*

Project HOPE is actively working in the original 20 communities to increase knowledge through education and promotion on a one-to-one basis, as well as in group sessions at the feeding centers and community demonstration gardens which are planted with high vitamin A and C vegetables. Each feeding center has a small garden attached to it which provides supplements to the CARE-provided food stuffs as well as serving as a teaching tool with mothers.

The Project HOPE HIS indicates that, in these communities, 829 children ages six to sixty months have received MOH Vitamin A capsules through Project HOPE.'

Objective 4: The number of mothers breastfeeding exclusively during the first six months will increase to 30%. The following were anticipated:

Year I (baseline)	10%
Year *2*	*20%*
Year 3	*30%*

No data are yet available on Project HOPE's activities or the success in promoting exclusive breastfeeding during the first six months. Data on breastfeeding practices will be available after the 199314 KPC survey. A new HIS should be designed to routinely present information for monitoring these activities using standardized indicators.

Objective 5: CHVs will *weigh 60% of children under two* years *on* a *bimonthly basis.* It was expected that weighing would increase:

Year 1:	*40%*
Year 2	*50%*

[7] 327 children one dose, 256 two doses, 156 three doses, 72 four doses, 17 five doses and 1 child reportedly received seven doses.

Year 3 60%

There are a reported 3,403 children under five years in the original 20 communities of the project. Two hundred and forty children under five are being weighed monthly in the feeding centers. Data on weighing of additional children in the 20 communities are weak. The central office HIS indicates that only 17 children were weighed in May 1993 and 18 children in June 1993. Project staff estimate on the basis of their supervision of the CHVs that about 3000 children are being routinely weighed. The final KPC survey will provide results on the number of children under two weighed on a bimonthly basis.

*Objective 6: 60% **of** mothers will be knowledgeable about reasons **for** prenatal care.* Outputs are the number of women trained.

Project HOPE reports that meeting with mothers are held routinely and commonly at the feeding centers. Because indicators were not clearly established at the project's onset, no data are presently available on the success of increasing knowledge about reasons for prenatal care; these data will be available after the final KPC survey.

*Objective 7: 60% **of** mothers will be knowledgeable about the need **for** prenatal care.* Outputs are the number of women trained.

Project HOPE reports that meetings with mothers are held routinely and commonly at the feeding centers. Because indicators were not clearly established at the project's onset, no data are presently available on the success of increasing knowledge about the need for prenatal care; these data will be available after the final KPC survey.

*Objective 8 . **The** number **of** women using modem contraceptives will increase by 5% over baseline by year* 3. Outputs are the number of women using modem contraception. It was anticipated that CHVs would educate 70% of high-risk women about modem contraceptives and provide barrier methods to women.

There are a reported 7,346 women of reproductive age (12-49 years) in the original 20 communities. Project HOPE has developed a referral mechanism with ASHONPLAFA, the local affiliate of International Planned Parenthood /Western Hemisphere for clinical methods. To date, the Project HOPE HIS has no data on the number of contraceptives supplied by CHVs or referrals made to ASHONPLAFA. A new HIS should be designed to routinely present information for monitoring these activities, using standardized indicators.

*Objective 9. **CHVs** and 70% **of** mothers will be able to recognize the key symptoms **of** pneumonia.* Outputs are the number of mothers trained in ALRI.

ARI is the leading cause of child mortality in Tegucigalpa The Project HOPE baseline study indicates 52% of all children under five years had an acute respiratory infection in the two weeks preceding the study. To date, Project HOPE has no data on the number of mothers trained in ALRI. A new HIS should be designed to routinely present information for monitoring these activities, using standardized indicators.

&RELEVANCE TO CHILD SURVIVAL PROBLEMS

The major causes of child mortality and morbidity in the project area are ARI and diarrheal disease. The mix and focus of Project HOPE interventions are appropriate and directly address the leading causes of mortality.

&EFFECTIVENESS

Project HOPE is behind schedule in achieving some of their stated objectives, such as transfer of responsibility for CS interventions in the original 20 communities to Las Crucitas and in the development of activities in the 24 new communities. Additionally, because the HIS simply does not present accurate, timely and sufficient information, it is hard to gauge the extent of the accomplishments to date. A good HIS must be developed and implemented.

Project HOPE deserves real credit, however, for its commitment and success in collaborating with the MOH. Such collaboration offers the potential for sustainable impact on the high-risk groups in the project areas. The MOH, the major service provider for the urban poor, is committed to access and availability throughout the marginal areas and to reducing infant and child mortality and morbidity. It needs all the help it can get. In real dollars, the MOH budget for the CESAMOs and CESARs of Tegucigalpa is the same as it was in 1987. Since then, however, the estimated population has risen from 500,000 to 800,000. The estimated 1994 population is 1,100,000, with no MOH budget increase. The MOH Metropolitan Region has 22 vehicles; only ten are operating and can be made to operate. MOH community-based activities in the marginal communities on the steep slopes and atop the hills of the city depends on the logistical support of collaborators like Project HOPE.

Project HOPE's integrating its activities with the MOH, however, means the pace and process is slower than it would be if Project HOPE were operating independently. In the long run, the slower integrated pace will be more effective than if Project HOPE worked rapidly and independently.

6. RELEVANCE TO DEVELOPMENT

The biggest barrier to meeting the basic needs of children is poverty and related problems of un/underemployment and low levels of education. Project HOPE has increased the ability of families to participate in and benefit from child survival activities by bringing those activities to the community level. Although the MOH has had child survival and CHVs since the mid 1980s, those activities were health centered based. MOH staff did not work on the weekends or in the evenings when families would be most likely to be at home for home visits or be able to attend community meetings. Project HOPE staff set an example of being community-directed and active in the community on a regular basis; the MOH staff with whom they are collaborating are now following that example.

Project HOPE is fostering an environment which increases community self-reliance. The four feeding centers, for example, are completely run by community women to whom Project HOPE has given training in planning, organization, and fund-raising. Maintenance of these feeding centers has been partially augmented by a new Project HOPE endeavor which, in addition to other activities (see next paragraph), aids mothers in the development of small

income-generating activities. The nutrition projects (community demonstration gardens and gardens connected to the feeding centers) aim to introduce vegetables high in Vitamin A and C into carbohydrate-based diets. Project HOPE-assisted community groups are working for improved water and sanitation.

In 1992, Project HOPE/Honduras added an income-generation program to its efforts to complement child survival activities. Due to the peri-urban location, many women work outside the home in income-generating activities such as food production, arts and crafts, selling and tailoring. Project HOPE is working with child survival-affiliated CHVs to identify interested participants and establish small rotating loan funds, called "village banks". This project, funded by an FHA/PVC and Project HOPE Matching Grant, supports the democratic process and empowers women by involving them in the management of their economic resources and participation in the productive sector of society. Approximately 80 banks will increase economic resources for about 2,400 women and their family members in the marginal areas of Tegucigalpa. Participants will be better able to provide essentials for their families (food, health care), and thus improve overall health status.

7. DESIGN AND IMPLEMENTATION

7.1 Design

Project HOPE has carefully designated its project area and expanded relationships with CESAMOS serving additional communities. The project has set measurable objectives, is open to change and responsive to evaluation.

There are design problems, but the responsibility for their existence and for solving them lies with the MOH and not Project HOPE. The problem lies in the overlap of international PVOs in the catchment area of different CESAMOS, (not in individual communities). A number of international PVOs (funded presumably by AID) are implementing child survival activities with a small number of communities in each of the CESAMOs. For example, the CESAMO San Francisco has a catchment area of 23 communities, about 52,000 people high on the slopes of the city. The CESAMO has two multi-disciplinary teams of six outreach workers each. The staff work with the International Eye Foundation which has CS activities and CHVs in ten communities. They also work with the Adventist Development and Relief Agency (ADRA) which has child survival activities and CHVs in another two communities. An additional five communities were designated to Project HOPE. The CHVs in those communities were trained using Project HOPE's curriculum; Project HOPE provides technical assistance to the staff on supporting those CHVs; and the CHVs themselves collect data for Project HOPE's HIS. Additionally, the MOH covers some communities which receive no international input (such as San Francisco's remaining six communities). The workload of the staff is increased because they deal with CHVs trained with slightly different foci and who must collect data for their respective international PVO using totally different reporting formats.'

[8] The mix of international PVOs varies from one CESAMO to another. In the catchment areas of other CESAMOs, Save the Children, World Vision and COASA are implementing child survival interventions.

7.2 Management and Use of Data

The formal Project HOPE health information system (HIS) is based upon four reports: a) the family census report; b) the family visits or contacts reports; c) the family immigration and migration report; d) surveys and questionnaires; and e) field staff reports (consisting of formatted data and daily journals of activities per community). The family census report is completed at the beginning of promotion with a family: it identifies members of the family, by cohorts, and lists the immunizations status of children and women ages 12 to 49 years. The family visit report is supposedly completed whenever a CHV: visits a family in their home and detects diarrhea, ARI, malnutrition or a lack of complete immunization in the children under five; pregnancy and/or lack of TT5; and whenever the CHV provides education about the major CS problems to a family. The immigration and migration report is meant to update the family census report. The Baseline Survey and KPC surveys are meant to reveal coverage and changes in knowledge and practices. Additionally, Project HOPE, in coilaboration with the MOH, conducted a questionnaire to assess the technical competence (child survival knowledge) of the CESAMO multi-disciplinary teams).

The formal HIS is not working. The data at the central level indicates very few activities are being carried out by the volunteers. Project HOPE staff and the evaluators believe that this data underreports CHV activities. For example, the Report of Activities Carried Out by Communities for the preceding 12 months (July 1, 1992 to July 1, 1993) by the 160 CHVs in the original 20 communities presents:

* data for only 11 of the 20 communities;
* and indicates that over those 12 months, only 83 cases of diarrhea and 113 cases of IRA were detected out of a population of 3403 children;
* and that in June, the last month for which monitoring of children's weight was available, less than 300 out of over 3000 children were weighed.

* Data coming from different levels of the system are inconsistent. The six volunteers whom the evaluation team interviewed stated that they visited 2-3 families a week and presented 3-5 reports a month; if these CHVs are representative, about 500 reports should be received each month. However, the Project HOPE MIS department states they receive about 100 reports a month from the 160 volunteers. The consolidated report for the previous 12 months, with reports on only 83 cases of diarrhea and 113 of IRA, indicates that there have been far fewer than 100 monthly reports.

- Project HOPE staff are not able to use these data, because there are so little of them, for decision making. Although staff submit regular field activity reports, these were not designed to present information on the necessary technical indicators. The new HIS must use the standardized indicators for monitoring these activities. Currently, supervision of auxiliary nurses is based upon these written reports and upon verbal debriefings, which presently provide fuller information then the written reports. Likewise, CHV supervision by the auxiliary nurses is conducted in a similar fashion.

Project HOPE must address these problems immediately and develop an HIS which provides timely, accurate and sufficient information at different levels for monitoring and decision making. Technical assistance will be necessary from Project HOPE's International Headquarters. The approach in the past has been to simply computerize

existing formats, which does not constitute a HIS. That approach should not be repeated.

* A new system should be designed for decision making. Project HOPE staff, in collaboration with the CHVs and MOH multi-disciplinary teams, should think, for each level of the child survival program: "What decisions do I make and what information do I need so that I can make wise decisions in a timely fashion?" "How often do I need those data?" "On whom do I depend and who depends upon me?" The system, including formats from top to bottom, should be designed to meet those needs, including those of tracking technical interventions.

• Project HOPE should work with the MOH and other international PVOs working in CS in Tegucigalpa (particularly those funded by AID) to develop a single CHV reporting format which meets the data needs of the CHV, the MOH, AID and the respective PVOs. If it proves impossible to develop a form which meets all these interests, Project HOPE should work with the MOH to develop a form which meets the needs of the CHV, the MOH, Project HOPE and thereby AID. Project HOPE should be a leader in this coordination with the MOH as it has been in other areas.

* Project HOPE, MOH and CHVs should be trained in the use of the system and in using data for decision making.

7.3 Community Education and Social Promotion

In the original 20 communities of the project, Project HOPE was directly involved in health promotion. This strategy, as discussed previously, is being phased out. In those communities and in the additional 24 new communities, Project HOPE's role is to provide technical assistance and training to the service providers. The revised strategy is more sustainable. Services do exist in the CESAMOs; the MOH needs assistance in improving and promoting those services. The messages conveyed are those developed by the MOH which has had since 1980 large AID-funded health sector projects with important child survival components.

7.4 Human Resources for Child Survival

There are 18 Project HOPE staff working full-time in this project. They are a group of competent, energetic, and committed people. Except for MIS, they are well equipped to implement this project. They are working in collaboration with a very supportive and determined MOH Area Chief who is resolved to take appropriate advantage of the assistance (technical and logistical) which Project HOPE is offering to the five CESAMOs. They are also working in collaboration with five CESAMO physician Directors and their five multi-disciplinary teams which work part-time on child survival activities assisted by Project HOPE and other international PVOs as well as those undertaken by the MOH without any outside help. Total MOH staff working part-time with Project HOPE is about 65.

Project HOPE plans to train 280 CHVs in the Project HOPE two-part 80 hour CHV training program. Two hundred and thirty one persons have received all 80 hours and another 139 have received the first part and 76 recruited persons will receive both

parts in the next year. These are multi-purpose CHVs providing health education and promotion on CDD, ARI, EPI, TB, nutrition, cholera, dengue and rabies.

There is a monthly four hour CHV meeting led by Project HOPE and the MOH for the volunteers in each CESAMO. The meeting has many purposes: motivation, supervision, continuing training, collection of reports and feedback to Project HOPE and the MOH on the success and appropriateness of the training provided to the CHVs

The expected and actual workload of the CHVs is unclear. Each CHV is assigned an average of 40 families in his/her community. The five CHVs whom the evaluators interviewed stated they saw 2-3 families a week or about 10 families a month. They stated that Project HOPE urged them to do a good job each time they visited a family: that "it was better to only visit two families well than ten families poorly." However, in order to achieve the CS objectives in this project, CHVs have to visit a majority of the families assigned to them on a regular basis and have, of course, to do it well.[9] The data in the central MIS indicates that all 160 "active" CHVS are not visiting assigned families with the regularity these six CHVs, selected out of CHVs attending the monthly meeting, report.

It is essential that Project HOPE more precisely define expectations for CHVs and be more willing to move into the passive status CHVs who are not meeting those expectations. Project HOPE should work with the MOH and a small group of CHVs to define an "active" CI-IV. Whereas CHVs should expect good supervision from the MOH, the communities, MOH and Project HOPE should expect a clearly defined minimum level of service from "active" CHVs. If necessary, Project HOPE and the MOH should train additional (beyond that planned) CHVs to maintain the desired number of active CHVs.

7.5 Supplies and Materials for Local Staff

Project HOPE has produced first-class training materials for the CHVs which have been copied by other international agencies working in Honduras and neighboring Central American counties." There are five manuals which become the property of each CI-IV: a manual on CDD, EPI, ARI, nutrition and family planning. The manuals are 40-70 pages long, full of illustrations, with a bright, attractive colored cover. Additionally, Project HOPE/MOH trainers use three excellent training guides (designed to complement the five Project HOPE training manuals): one on illnesses of children, one on nutrition and one on family education." These include training exercises and clearly present the objective of an exercise, its preparation and steps. Like the

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[9] The objectives are stated in coverage of 50-70%. Ie, "CHVs will monitor the weight of children under two at least bimonthly" and "60% of mothers will be more knowledgeable about reasons for prenatal care."

[10] This evaluator noted their use by Action Medica Cristiana in Nicaragua.

[11] These were produced in collaboration with World Neighbors, the World Aid Committee of Christian Reformed Churches of Canada and the United States and CONSEDE, a group of evangelical institutions in development.

manuals, they are full of culturally appropriate illustrations. Project HOPE has also contributed training supplies to each CESAMO with which it is collaborating: blackboards, flip charts, magic markers, instructional/educational videos, etc. There are ample and appropriate materials, supplies and equipment for the CHVs Project HOPE has trained and for the CESAMOs in their collaboration with Project HOPE.

7.6 Quality

The Project Paper and Detailed Implementation Plan were written in the belief that the MOH field staff (multi-disciplinary teams), who had received MOH technical training on the various child survival interventions, were technically competent. Project HOPE's role was to assist them in the recruiting, training and supervising of CHVs. Recently, however, Project HOPE, puzzled by difftculties in getting the teams to supervise CHVs in the community, developed and implemented, in collaboration with the MOH leadership, a "Test of Child Survival Knowledge" for the multi-disciplinary teams. All members of the teams (auxiliary nurses, social workers, health promoter and vector control personnel) took the test in each of the five CESAMOs.

The test itself was practical and based on case histories. Staff were asked what they would do when they encountered cases of diarrhea, ARI, incomplete immunization and TB. A perfect score would have been 100. The results of the test were not good. Average scores were low and the range of knowledge was very great. Some members of the teams, who are supposed to be supervising the activities of the CHVs, know very little about CDD, ARI, EPI and TB. See Tables 1 and 2.

Table 1: Average Test Scores for Specific CS Interventions by CESAMO

	Average Team Score on Specific CS Interventions				
CESAMO	ARI	CDD	EPI	TB	total
Villa Adela	48	66	88	64	266
Las Crucitas	59	70	52	52	233
Alemania	58	70	58	61	247
3 de Mayo	55	79	52	72	258
San Francisco	33	42	61	44	180
average	51	65	62	59	

Table 2: Range of Test Scores on Specific CS Interventions, by CESAMO

	Range of Test Scores on Specific CS Interventions			
CESAMO	ARI	CDD	EPI	TB
Villa Adela	62-25	70-60	95-80	71-53
Las Crucitas	92-10	84-13	80-10	86-20
Alemania	82-27	96-40	98-5	89-32
3 de Mayo	76-32	96-67	80-20	90-48
San Francisco	50-30	56-13	77-32	48-42

The MOH and Project HOPE are appropriately concerned about the results of this test. The MOH has asked and Project HOPE has agreed to undertake technical training of the multi-disciplinary teams. Project HOPE staff state they can begin such training without running over the current budget. The focus for the next year should be on training staff in the five CESAMOs in which Project HOPE is currently collaborating with the MOH and bringing that staff to an agreed upon level of competence. These five CESAMOS could then serve as models for the other ten CESAMOs in the metropolitan region.

- The training should begin with ARI since it is both the leading cause of child mortality and the area in which test scores were the lowest in all CESAMOs.

* The training should be directed toward developing a previously defined level of competence, agreed upon by MOH Directors, field teams and Project HOPE This evaluator urges that the level of mastery be a minimum of 90% of the CS content. If the field teams master 90% and correctly train and supervise the CHVs at that level, and; the CHVs were to master and correctly pass on 90% of what they have learned to mothers and communities, these families would

only be receiving 81% of the knowledge which was identified as important in the first place.

- Training should be in-service, practical and repeated until the level of competence is achieved.
- Training sessions should begin with a pre-test of knowledge and end with a post-test.

7.7 Supervision and Monitoring

Project HOPE supervision and monitoring of its own staff is regular, frequent, and systematic. Staff are field-oriented and lead and supervise by good example as well as advice. Their relationships with the CI-IVs appeared warm and supportive. In the original 20 communities, they have spent one hour with each CHV every week or every other week; they have had responsibility for the success of the CHVs' work. That responsibility will be turned over to Las Crucitas staff in the next few months. Responsibility for supervising the activities of the CI-IVs in the 24 additional communities in the catchment areas of San Francisco, Alemania, Villa Adela and 3 de Mayo has been the CESAMO's from the beginning. Project HOPE's role is technical assistance to the multi-disciplinary teams.

The supervision and monitoring requirements for the remainder of the project are two-fold:

- Project HOPE must develop a useful HIS which produces data on the key indicators presented in the DIP on a routine basis.

*Project HOPE must either assist the MOH multi-disciplinary teams to reach a minimum level of technical competence so that the teams are indeed competent to supervise the CHVs or Project HOPE must chose another child survival strategy in Tegucigalpa.

7.8 Use of Central Funding

The support from the Project HOPE international Headquarters has been appropriate and useful. There is at least one staff visit a year. In the past year there have been three, which were cost-shared with other ongoing MCH activities. Project staff talk at least once a week with Headquarters.

A.I.D. has given the project $75,000 for administrative monitoring and technical support of the project. Those funds will be critically useful in assisting the project in Tegucigalpa to develop a useful HIS.

7.9 PVO's Use of Technical Support

The project sought and received local technical assistance to develop its present HIS. At the time, because Project HOPE staff in Tegucigalpa knew little about HIS, the technical assistance seemed good. Unfortunately, however, the local advisors viewed the assignment as one of developing software to computerize formats. They did so and the result is that the Project HOPE computers produce nicely laid out activity reports

with key indicators, but no data. As discussed in Section 7.2, now Project HOPE must start from scratch to design a system from the level of the CHVs which meets monitoring and decision making needs at each level.

7.10 Assessment of Counterpart Relationships

Project HOPE's chief counterpart is the MOH with whom Project HOPE works very closely. MOH staff told the evaluators that Project HOPE is unique among all the international agencies working in Tegucigalpa in the extent to which it tried to collaborate and integrate its activities with the CESAMOs. As indicated previously, such integration has its pros and cons. The pros are that there is the potential for sustainable impact. The cons are that the MOH teams do not currently have the technical skills to take on supervision of the CHVS. There is, however, open dialogue on this issue between Project HOPE, the MOH Area Chief, the Director of each CESAMO and the teams themselves. The number one recommendation of this report is that Project HOPE and the MOH move immediately to increase the technical competence of the CESAMO multi-disciplinary teams.

7.11 Referral Relationships

The CHVs refer cases of diarrhea, ARI, immunization and pregnancy to the local CESAMO which is within a relatively easy distance from all communities. Recently, Project HOPE and the MOH developed a referral card for the CHV to give the client which will facilitate service at the CESAMO. Women interested in IUDs or sterilization are referred to ASHONPLAFA.

7.12 PVOMGO Networking

Project HOPE collaborates very effectively with a number of other PVOs and NGOs working in health and child survival in Tegucigalpa. Project HOPE has collaborated with CARE which has given feeding centers food staffs and nutrition education; CARE in turn uses Project HOPE's training materials for its staff Very useful, also, has been the collaboration with the Honduras Association for Breastfeeding which has shared its educational materials with Project HOPE.

Further networking and collaboration is necessary to produce the unified single CHV format mentioned in Section 7.1.

7.13 Budget Management

Expenditures to date are about on target except for salaries on which Project HOPE is overspent. While the DIP programmed the transfer of the twenty communities in PA1 for the end of the second project year, this has not been possible due to the increasing need for training of MOH personnel. Because the four auxiliaries are essential to the program they have, consequently, remained on Project HOPE's payroll. The Project HOPE Director expects she will be able to cover this overexpenditure by cutting costs in other areas. All project funds will be spent at the end of the project.

8. SUSTAINABILITY

Project HOPE has undertaken a number of important steps to promote project sustainability:

* INTEGRATION WITH THE MOH: Project HOPE altered its strategy from working parallel to the MOH to integrating its activities with the MOH. Project HOPE is supporting the vitally important institution which will continue child survival activities when Project HOPE has left Tegucigalpa.

* COMMUNITY PARTICIPATION: Project HOPE has worked to place responsibility for child survival activities in the hands of the community. In each of the original 20 communities, a community group has been formed or has been strengthened to assist child survival activities. These groups value the child survival activities: the four feeding centers, for example, are run by the community in which they function.

- TRAINING: Project HOPE has trained and will continue to train MOH staff. There has been both skills development and the development of a more service-oriented attitude on the part of MOH field teams.

- PERCEPTION OF EFFECTIVENESS: Project activities are seen as effective by both the communities and the MOH. The MOH would like Project HOPE to expand its activities into additional communities, either new communities served by the five CESAMOs with which Project HOPE is presently collaborating or into communities served by one or more of the other ten CESAMOs in the Metropolitan region.

The subject of incentives is debated: what constitutes an incentive and which incentives can be sustained by the MOH. Project HOPE, like the other international PVOs and NGOs in Tegucigalpa, has provided the CI-IVs trained and supervised by Project HOPE with incentives with both extrinsic and intrinsic value. At the monthly CHV meetings in the original 20 communities, Project HOPE gave each CHV a bag with items donated to Project HOPE's international headquarters and sent to Tegucigalpa: usually, soap, shampoo and hygienic napkins. Project HOPE also routinely provided incentives with an intrinsic value: regular supervision, training, personal interest and affirmation.

Independently of any international PVO, the MOH has also provided incentives to the CI-IVs who have worked with the MOH . It gave a bag of donated food and, most importantly, free and quicker health attention for the CHV and his/her children at MOH health facilities. The identity card which everyone must present at a health facility for attention states, for MOH CI-IVs, that attention is free. Although the MOH leadership recognizes that a bag of free food and free medical attention are incentives, the multi-disciplinary teams have not recognized them as such, but rather have been concerned that they are not able to sustain the bag of personal products Project HOPE has given. Accordingly, Project HOPE is no longer going to give the CHVs the bag of donated goods. What must be continued, however, are the incentives with an intrinsic value: regular supervision, training, personal interest and affirmation. Project HOPE's technical assistance to the MOH will focus on the importance of such incentives.

9. RECURRENT COSTS AND COST RECOVERY MECHANISMS

The project managers have a good idea of the recurrent costs of the two different strategies they have employed in Tegucigalpa. The first strategy, in the original 20 communities, of working directly with the CHVs had recurrent costs associated with the high level of attention and materials which Project HOPE gave the CHVs. Project HOPE is in the process of phasing-over this strategy: the goal is for the Las Crucitas CESAMO to assume full responsibility for project activities in early 1994. If that phase-over is successful, the principal outstanding recurrent cost would be transportation.

Transportation is also the principal recurrent cost and source of concern for the additional 24 communities covered by the other four CESAMOs as well. The project has three vehicles which have transported both the CESAMO field teams and the CHVs. Although Project HOPE will donate vehicles to the MOH when it leaves Tegucigalpa, there is no assurance any of the vehicles will go to support activities in these five CESAMOs. Project HOPE and the MOH recognize it as a problem with little likelihood of solution. The best they can do is look for efficient ways to supervise and support the CHVs, minimizing dependence on these vehicles.

The Project HOPE child survival project is. itself, efficient. The office is based on the grounds of Las Crucitas which picks up the project's water and electricity bills. The office and furnishings are adequate, simple and basic. Costs are shared with two other A.I.D.-funded Project HOPE projects (income generation and maternal child health care). Costs per beneficiary are very reasonable.

10. RECOMMENDATIONS

10.1.Technical CS training for the CESAMO multi-disciplinary teams

Project HOPE should assist the MOH to develop and implement **a** program of in-service training in the key CS interventions of **ARI,** CDD, EPI, nutrition and maternal health for the CESAMO field teams **(equipo** de carnpo). The focus for the next year should be on training staff of the five CESAMOs with which Project HOPE is currently collaborating and bringing that staff to an agreed upon level of competence. These five CESAMOS could then serve as models for the other ten CESAMOs in the metropolitan region.

* The training should begin with ARI since it is both the leading cause of child mortality and the area in which test scores were the lowest in all CESAMOs.
* The training should be directed toward developing a previously defined level of competence, agreed upon by MOH Directors, field teams and Project HOPE This evaluator urges that the level of mastery be a minimum of 90% of the CS content. If the field teams master 90% and correctly train and supervise the CHVs at that level, and the **CHVs** were to master and correctly pass on 90% of what they have learned to mothers and communities, these families would only be receiving 81% of the knowledge which was identified as important in the first place.
* Training should be in-service, practical and repeated until the level of competence is achieved.
* Training sessions should begin with a pre-test of knowledge and end with a post-test.

10.2 CHV incentives

Project HOPE should sponsor a workshop on" CHV Incentives" for MOH field teams and other **PVOs** working in the metropolitan region. The objectives would be to:

* reinforce supervisory knowledge, attitudes and skills on the non-monetary incentives which are so essential to CHV retention and performance - good training and supervision;
* discuss the importance of those monetary incentives which the MOH is able to provide to **CHVs** and identify ways to maximize full CI-IV use of those incentives.

103 A single unified CHV reporting format

Project HOPE should work with the MOH and other international **PVOs** working in CS in Tegucigalpa (particularly those funded by AID) to develop a single CI-IV reporting format which meets **the** data needs of the CI-IV, the MOH, AID and the respective **PVOs**. If it proves impossible to develop a form which meets all these interests, Project HOPE should work with the MOH to develop **a** form which meets the needs of the **CHV,** the MOH, Project HOPE and thereby AID. Project HOPE should be **a** leader in this coordination with the MOH as it has been in **other areas.**

10.4. A Project HOPE HIS

Project HOPE must develop a HIS which provides timely, accurate and sufficient data for monitoring the progress of its programs on a regular basis. The system should be developed in collaboration **with** staff (and the MOH for CHV reporting). Staff and CHV should be trained and supervised in its use.

103. More precisely defined expectations for CHVs

Project HOPE should work with the MOH to define an "active" CHV and be more willing to move into the passive status CHVs who are not meeting those expectations. Whereas CHVs should expect good supervision from the MOH, the communities, MOH and Project HOPE should expect a clearly defined minimum level of service from "active" CHVs. If necessary, Project HOPE and the MOH should train additional (beyond that planned) CHVs to maintain the desired number of active CHVs.

10.6. Expansion

At the invitation of, and dependent upon the needs of the MOH and each CESAMO, Hope should give priority to expanding its collaboration with the MOH in additional communities covered by the five CESAMOS with which Project HOPE is currently collaborating, if there are needy communities without international assistance in the catchment area of those five. I am recommending that Project HOPE give priority to the current five CESAMOS for two reasons:

* It is essential to develop multi-disciplinary teams truly capable of supervising and supporting the child survival activities in their catchment area Expansion into additional CESAMOs should be undertaken after the MOH and Project HOPE believe that they have developed a successful training program for the multipurpose teams which can be replicated in additional CESAMOs.

* It is more efficient and there is a greater chance for impact if Project HOPE works with multi-disciplinary teams and CHVs covering many communities of a single CESAMO rather than a few communities in many CESAMOs.

APPENDIX 1: COUNTRY PROJECT PIPELINE ANALYSIS

HEADQUARTERS

COST ELEMENTS	Actual Expenditures To Date (08/01/91 to 08/31/93) AID	PVO	TOTAL	Projected Expenditures Against Remaining Obligated Funds (09/01/93 to 08/31/94) AID	PVO	TOTAL	Total Revised Budget (Columns 1 & 2 I (08/01/91 to 08/31/94) AID	PVO	TOTAL
1. PROCUREMENT									
A. Supplies	90	47	137	53	0	53	143	47	190
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants									
1. Locdl	0	0	0	0	0	0	0	0	0
2. Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	90	67	137	53	0	53	143	47	190
II. EVALUATION/SUB-TOTAL II	0	0	0	0	0	0	0	0	0
III. INDIRECT COSTS									
Overhead al HQ/HO (55%)	5,615	6,108	11,753	26,540	4,621	31,161	32.185	10,729	42,916
SUB-TOTAL III	5,645	6,108	11,753	26,540	1,621	31,161	32,185	10,729	42,914
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
1. Technical	8,046	3,358	11,404	8,761	3,w	12,206	16,807	6,801	23,608
2. Administrative	1,815	771	2,616	4,001	1,378	5,379	5,846	2,169	7,995
3. Support	5,368	1,982	7,350	3,832	l a	3,850	9,200	2.000	11,200
8.' Travel/Per Diems									
1. In-country	1,219	405	1,624	781	95	876	2,000	500	2,500
2. International	3,027	1,155	1,180	1,973	347	2,320	5,000	1,500	6,500
C. Other Direct Costs									
Utilities, Printing, rent, maintenance, etc.)	727	280	1,007	3,092	994	4,086	3,819	1,274	5,093
SUB-TOTAL IV	20,232	7,919	28, 181	22,440	6,275	28,715	42,672	14,224	56,896
TOTAL HEADQUARTERS	25,967	11,101	40,071	49,033	lo.896	59,929	75,000	25,000	100,000

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FIELD	Actual Expenditures To Date (08/01/91 to 08/31/93)			Projected Expenditures Against Remaining Obligated Funds (09/01/93 to 08/31/94)			Total Revised Budget (Columns 1 & 2) (08/01/91 to 08/31/94)		
COST ELEMENTS	AID	Pvo	TOTAL	AID	PVO	TOTAL	AID	Pvo	TOTAL
I. PROCUREMENT									
A. Supplies	0	14,638	14,638	12,323	15,642	27,985	12,323	30,300	12,623
B. Equipment	0	17,667	17,667	0	27,150	27,650	0	0,117	15,117
C. Services/Consultants									
1. Local	2,617	659	3,076	2,769	1,341	4,110	5,186	2,000	7, lab
2. Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	2,617	32,964	35,381	15,092	44,453	59,545	17,509	77,617	94,926
II. EVALUATION/SUB-TOTAL II	3,955	0	3,955	13,857	0	13,857	17,812	0	17,812
III. INDIRECT COSTS									
Overhead/Field (55%)	45,284	23,544	68,828	30,655	56	30,711	75,939	23,600	99,539
SUB-TOTAL III	45,284	23,544	68,828	30,655	56	30,711	75,939	23,600	59,539
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months seperately)									
1. Technical	57,459	13,147	70,906	36,953	0	34,953	92,412	13,447	105,859
2. Administrative	0	0	0	0	0	0	0	0	0
3. Support	41,369	9,378	50,747	26,697	0	26.697	68,066	9,378	77,444
B. Travel/Per Diems									
1. In-country	24,361	5,493	29,854	39,418	3,024	42,442	63,779	8,517	72,296
2. International	1,573	537	2,110	15,241	271	15,512	16,814	808	17,622
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	36,657	6,097	40,754	38,012	2,402	40,414	72,669	8,499	81,168
SUB-TOTAL IV	159,419	34,952	194,371	154,321	5,697	160,018	313,740	40,649	-,309
TOTAL FIELD	211,075	91,460	302,535	213,925	50,206	264,131	425,000	141,666	566,666

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TOTAL - FIELD & HEADQUARTERS

	Actual Expenditures To Date (08/01/91 to 08/31/93)			Projected Expenditures Against Remaining Obligated Funds (09/01/93 to 08/31/94)			Total Revised Budget (Columns 1 & 2 1 (08/01/91 to 08/31/94)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	Pvo	TOTAL
TOTAL HEADQUARTERS	25,967	14,104	40,071	49,033	10,896	59,929	75,000	25,000	100,000
TOTAL FIELD	211,075	91,460	302,535	213,925	50,206	264,131	425,000	141,666	566,666
TOTAL	237,012	105,564	342,606	262,958	61,102	324,060	500,000	166,666	666,666

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APPENDIX 2: EVALUATION SCHEDULE

July 20	Review of documents
July 31	Arrival in Tegucigalpa
August 2, 1993	Review of documents
August 3	Meetings with Project HOPE Director and Coordinator
August 4	Meeting with the Child Survival staff Meeting with Evaluation Team
August 5	Meetings at four CESAMOs with the Director and “equipos de campo”
August 6	Meeting at the fifth CESAMO with the Director and "equipo de campo” Visit to two feeding centers Visit to community garden project
August 7	Review and plan
August 8	Meeting and training of the CHV Interviews with CHVs
August 9	Meeting with Ministry of Public Health, Metropolitan Region
August 10	Meetings with Project HOPE staff
August 11	Presentation and discussion of evaluation recommendations and luncheon with Ministry staff, the Directors and equipos de campo” from the five CESAMOs and Project HOPE child survival staff A meeting was also scheduled for this day with AID/Honduras which the Mission was forced to cancel at the last minute due to an emergency
August 12	Depart Honduras

APPENDIX 3: PERSONS INTERVIEWED

PROJECT HOPE
Carol Elwin, Director
Alicia Leiva, Coordinator
the two supervising nurses, two social workers, seven auxiliary nurses, and one agricultural technician.

MINISTRY OF HEALTH, METROPOLITAN REGION
Dr. Mejia de Cruz, Regional Director
Dr. Hemandez, Regional Subdirector
Dr. Janet Mejia, Chief of Region 1
Dr. Suyapa Prudot, Chief of Monitoring and Evaluation
Lit. Francisca Elena Ordonez, Chief of the Department of Social Work

CESAMO San Francisco
Dr. Dagoberto Torres, CESAMO Director
the twelve members of the "equips de campo" from the following disciplines: nursing, social work, basic sanitation, health promotion and vector control

CESAMO 3 de Mayo
Dr. Teresa Reyes, CESAMO Director
the eight members of the "equips de campo" from the following disciplines: nursing, social work, basic sanitation, health promotion and vector control

CESAMO Las Crucitas
the twelve members of the "equips de campo" from the following disciplines: social work, basic sanitation, health promotion and vector control

CESAMO Alemania
Dr. Veronica Maradiaga, CESAMO Director
the eight members of the "equips de campo" from the following disciplines: nursing, social work, basic sanitation, health promotion and vector control

CESAMO Villa Adela
Dr. Gustavo Ramirez, CESAMO Director
the twelve members of the "equips de campo" from the following disciplines: nursing, social work, basic sanitation, health promotion and vector control

COMMUNITY GROUPS
Women's Club (Club de Amas de Casa) - Colonia Obrera
Women's Club (Club de Amas de Casa) - Lomas de Norte
Women's Club (Club de Amas de Casa) - Col. Smith

COMMUNITY HEALTH VOLUNTEERS

Amparo Arias
Ana Maria Inestroza
Santa Lucia Valeriano
Martha Rivera
Olga Marina Suazo
Glenda Valladares

APPENDIX 4: MATERIALS REVIEWED

Proposal to USAID, PVO Child Survival Grants Program, FY 1991, SUSTAINING AND REPLICATING CHILD SURVIVAL ACTIVITIES IN PERI-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS

SUSTAINING AND REPLICATING CHILD SURVIVAL ACTIVITIES IN PERI-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS, Baseline Survey, June 1, 1991

SUSTAINING AND REPLICATING CHILD SURVIVAL ACTIVITIES IN PERI-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS, Detailed Implementation Plan, June 1, 1992

PVO Child Survival Grants Program, 1992, SUSTAINING AND REPLICATING CHILD SURVIVAL ACTIVITIES IN PERJ-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS, Annual Report Year 1.

Project HOPE/Honduras Quarterly Reports including *Informe de Los Resultados de la Prueba de Conocimientos en las Intervenciones de CED, IRA, PAI, TB*

The following materials were reviewed and copies are attached.

Project HOPE, Programa Superviviencia Infantil, Manual-Guia 1, CONTROL DE ENFERMEDADES DIARREICAS, Para personal Voluntario de Salud

Project HOPE, Programa Superviviencia Infantil, Manual-Guia 2, PROGRAMA AMPLIADO DE INMUNIZACIONES, Para personal Voluntario de Salud

Project HOPE, Programa Superviviencia Infantil, Manual-Guia 3, INFECCIONES RESPIRATORIAS AGUDAS, Para personal Voluntario de Salud

Project HOPE, Programa Superviviencia Infantil, Manual-Guia 4, NUTRICION, Para personal Voluntario de Salud

Project HOPE, Programa Superviviencia Infantil, Manual-Guia 5, PLANIFICACION FAMILIAR, Para personal Voluntario de Salud

CONSEDE, CRWRC AND VECINOS MUNDIALES, Guia de Tecnicas 1, ENFERMEDADES DEL NINO

CONSEDE, CRWRC AND VECINOS MUNDIALES, Guia de Tecnicas 2, NUTRICION

CONSEDE, CRWRC AND VECINOS MUNDIALES, Guia Tecnicas 3, EDUCACION FAMILIAR

Guias Tecnicas, Sobre de Materiales, CONSEDE, CRWRC AND VECINOS MUNDIALES,